DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:	2. STATE
03-09	**NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
Effective October 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart C

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $148,753,400
b. FFY 2005 $152,884,668

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Affected pages are Attachment 4.19-D, pages 2-25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Affected pages are Attachment 4.19-D, pages 2-28

10. SUBJECT OF AMENDMENT:
Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Odom

13. TYPED NAME:
Carmen Hooker Odom

14. TITLE:
Secretary

15. DATE SUBMITTED:
9/23/03

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
SEP 23 2003

18. DATE APPROVED:
APR - 5 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
OCT - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179 (07-92)

Medical Assistance
State North Carolina

Payment for Services – Prospective Reimbursement Plan for Nursing Care Facilities

.0102 RATE SETTING METHODS

(a) A rate for nursing facility care is determined quarterly for each facility to be effective for dates of service for a three-month period beginning the first day of each calendar quarter. Rates are derived from either desk or field audited cost reports for a base year period to be selected by the state. For rates effective October 1, 2003, the FY01 cost reports shall be used as the base year period. Cost reports are filed and audited under provisions set forth in Section .0104.

(b) Each prospective rate consists of two components – a direct care rate and an indirect rate – computed and applied as follows:

(1) The direct care rate is that portion of the Medicaid daily rate that is attributable to:

(A) Case-mix adjusted costs defined as

(i) registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

(ii) a direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and

(iii) the direct allowable cost of contracted services for RN, LPN and nurse aide staff from outside staffing companies.

(B) Non-case-mix adjusted costs defined as

(i) Nursing supplies;

(ii) Dietary or Food Service;

(iii) Patient Activities;

(iv) Social Services

(v) A direct allocation or proportionate allocation of allowable payroll taxes and employee benefits; and

(vi) Medicaid cost of Direct Ancillary services.

(2) Each facility's direct care rate shall be determined as follows:

(A) The per diem case-mix adjusted cost is determined by dividing the facility's case-mix adjusted base year cost by the facility's total base year inpatient days. This case-mix adjusted base year cost per diem shall be trended forward using the index factor set forth in Section .0102(e). A per diem neutralized case-mix adjusted cost is then calculated by dividing each facility's case-mix adjusted per diem cost by the facility cost report period case-mix index. The facility cost report period case-mix index is the resident-weighted average of quarterly facility-wide average case-mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the facility's base year cost reporting period. Example: An October 1, 2000 – September 2001 cost report period would use the facility-wide average case-mix indices for quarters ending December 31, 2000, March 31, 2001, June 30, 2001, and September 30, 2001.

(B) The per diem non-case-mix adjusted cost is determined by dividing the facility's non-case-mix adjusted base year cost, excluding the Medicaid cost of direct ancillary services, by the facility's total base year inpatient days plus the facility's Medicaid cost of direct ancillary services base year cost divided by the facility's total base year Medicaid resident days. This non-case-mix adjusted base year cost per diem shall be trended forward using the index factor set forth in Section .0102(e).

(C) The base year per diem neutralized case-mix adjusted cost and the base year per diem non-case-mix adjusted cost are summed for each nursing facility. Each facility's base year per diem result is arrayed from low to high and the Medicaid-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

(D) The statewide direct care ceiling is established at 110 percent of the base year neutralized case-mix adjusted and non-case mix adjusted Medicaid-day-weighted median cost.

(E) For each nursing facility, the statewide direct care ceiling shall be apportioned between the per diem case-mix adjusted component and the per diem non-case-mix adjusted component using the facility-specific percentages determined in .0102(b)(2)(C).

(F) On a quarterly basis, each facility's direct care rate shall be adjusted to account for changes in its Medicaid average case-mix index. The facility's direct care rate is determined as the lesser of (i) or (ii) as calculated below plus an incentive allowance.

(i) The facility's specific case-mix adjusted component of the statewide ceiling times the facility's Medicaid average case-mix index, plus each facility's specific non-case mix adjusted component of the statewide ceiling.

(ii) The facility's per diem neutralized case-mix adjusted cost times the Medicaid average case-mix index, plus the facility's per diem non-case-mix adjusted cost.

Effective October 1, 2003, the incentive allowance is equal to 50% times the difference (if greater than zero) of (i) minus (ii) as calculated above. The Division of Medical Assistance may negotiate direct rates that exceed the facility's specific direct care ceiling for ventilator dependent and head injury patients. Payment of such special direct care rates shall be made only after specific prior approval of the Division of Medical Assistance.

(G) For rates effective October 1, 2003, the Medicaid average case-mix index calculated as of March 31, 2003 shall be used to adjust the case-mix adjusted component of the statewide direct care ceiling. For rates effective January 1, 2004 and thereafter, the prior quarters Medicaid average case-mix index will be used to adjust the case-mix adjusted component of the statewide direct care ceiling. Example: January 1, 2004 rate will use the Medicaid average case-mix index calculated as of September 30, 2003.

(H) The statewide direct care ceiling will be adjusted annually using the index factor set forth in Section .0102(e). The facility's base year per diem neutralized case-mix adjusted cost plus the facility's base year per diem non-case-mix adjusted cost will be adjusted annually using the index factor set forth in Section .0102(e).

(3) The indirect rate is intended to cover the following costs of an efficiently and economically operated facility:

(A) Administrative and General,
(B) Laundry and Linen,
(C) Housekeeping,
(D) Operation of Plant and Maintenance/Non-Capital,
(E) Capital/Lease,
(F) Medicaid cost of Indirect Ancillary Services.

(4) Effective for dates of service beginning October 1, 2003, the indirect rate will be standard for all nursing facilities. Each facility's per diem indirect cost is the sum of 1)the facility's indirect base year cost, excluding the Medicaid cost of indirect ancillary services, divided by the facility's total base year inpatient days plus 2) the facility's Medicaid cost of indirect ancillary services base year cost divided by the facility's total base year Medicaid resident days. The base year per diem indirect cost, excluding property ownership and use and mortgage interest shall be trended forward using the index factor set forth in Section .0102(e) of this section. Each facility's base year per diem indirect cost is arrayed from low to high and the Medicaid-day-weighted median cost is determined. The indirect rate is established at 100 percent of the Medicaid-day-weighted median cost. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(c) Nursing facility assessments. An adjustment to the nursing facility payment rate calculated in accordance with Section .0102(b) is established, effective October 1, 2003, to reimburse Medicaid participating nursing facilities for the provider's assessment costs that are incurred for the care of North Carolina Medicaid residents. No adjustment will be made for the provider's assessment costs that are incurred for the care of privately paying residents or others who are not Medicaid eligible.

(d) Return on Equity. Effective October 1, 2003 through September 30, 2004, the nursing facility payment rate calculated in accordance with Section .0102(b) shall be adjusted to include a return on equity capital add-on for those proprietary providers who received a FY01 return on equity capital payment. The return on equity capital add-on is equal to the facility's total FY01 return on equity capital payment divided by the facility's base year total Medicaid resident days.

(e) Index factor. The index factor shall be based on the Skilled Nursing Facility Market Basket without Capital Index published by Global Insight using the most current quarterly publication available annually as of August 1. The index factor shall not exceed that approved by the North Carolina General Assembly. If necessary, the Division of Medical Assistance shall adjust the annual index factor or rates in order to prevent payment rates from exceeding upper payment limits established by Federal Regulations.

(f) New Facilities and Transfer of Ownership of Existing Facilities

(1) New facilities are those entities whose beds have not previously been certified to participate or otherwise participated in the Medicaid program immediately prior to the operation of the new owner . A new facility's rate will be determined as follows and will continue to be reimbursed under this section until the incentive allowance percentage referenced in Section .0102(b)(2)(F) is equal to 100%:

(A) The direct care rate for new facilities will be equal to the statewide Medicaid day-weighted average direct care rate that is calculated effective on the 1st day of each calendar quarter. After the second full calendar quarter of operation, the statewide Medicaid day-weighted average direct care rate in effect for the facility shall be adjusted to reflect the facility's Medicaid acuity and the facility's direct care rate is calculated as the sum of the following:

(i) 65 percent of the statewide Medicaid day-weighted average direct care rate multiplied by the ratio of the facility's Medicaid average case-mix index (numerator) to the statewide Medicaid day-weighted average Medicaid case-mix index (denominator).

(ii) The statewide Medicaid day-weighted average direct care rate times 35%.

(B) The indirect rate for a new facility will be equal to the standard indirect rate in effect at the time the facility is enrolled in the Medicaid Program. The indirect rate shall be adjusted annually by the index factor set forth in Section .0102(e).

(C) A new facility's rate will include also the nursing assessment adjustment calculated in accordance with Section .0102(c).

(2) Transfer of ownership of existing facilities. Transfer of ownership means, for reimbursement purposes, a change in the majority ownership that does not involve related parties or related entities including, but not limited to, corporations, partnerships and limited liability companies. Majority ownership is defined as an individual or entity that owns more than 50 percent of the entity, which is the subject of the transaction. The following applies to the transfer of ownership of a nursing facility:

(A) For any facility that transfers ownership, the new owner shall receive a per diem rate equal to the previous owner's per diem rate less any return on equity adjustment received by the previous owner, rate adjusted quarterly to account for changes in its Medicaid average case-mix index. The old provider's base year cost report shall become the new facility's base year cost report until the new owner has a cost report included in a base year rate setting.

(B) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid program, the Division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control of ownership for any facility certified for participation in Medicaid, the Division shall recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid program, regardless of when the services were rendered.

(g) Each out-of-state provider is reimbursed at the lower of the appropriate North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate or the provider's payment rate as established by the state in which the provider is located. For patients with special needs who must be placed in specialized out-of-state facilities, a payment rate that exceeds the North Carolina statewide Medicaid day-weighted average direct care rate plus the indirect rate may be negotiated. A facilities' negotiated rate for specialized services is based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review.

(h) Specialized Service Rates:

(1) Head Injury Intensive Rehabilitation Services –

(A) A single all-inclusive prospective rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive rehabilitation services for head injured patients as specified by criteria in Appendix 3 to Attachment 3.1-A of the State Plan. The rate may exceed the maximum rate applicable to other Nursing Facility services. A facility must specialize to the extent of staffing at least fifty percent (50%) of its nursing facility licensed beds for intensive head injury rehabilitation services. The facility must also be accredited by the Commission for the Accreditation of Rehabilitation Facilities (CARF).

(B) A facility's initial rate is negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review upon the completion of an audited full year cost report. The negotiated rate shall not be less than the North Carolina statewide Medicaid day-weighted average direct care plus the indirect rate. A complete description of the facility's medical program must also be provided. Rates in subsequent years are determined by applying the index factor as set forth in Section .0102(e) to the rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice.

(C) Cost reports for this service shall be filed in accordance with Section .0104 but there shall not be cost settlements for any difference between cost and payments. The negotiated rate is considered to provide payment for all financial considerations and shall not include the return on equity adjustment as defined in Section .0102 but shall include the nursing assessment adjustment as defined in Section .0102. The negotiated rate will be paid to the facility for services provided to head injured patients only. The per diem payment rate for non-head injured patients shall be the rate calculated in accordance with Section .0102 (b)–(e).

(1) Ventilator Services:

(A) Ventilator services approved for nursing facilities providing intensive services or ventilator dependent patients are reimbursed at higher direct rates as described in Section .0102(b)(2).

(B) A facility's initial direct rate shall be negotiated based on budget projections of revenues, allowable costs, patient days, staffing and wages, at a level no greater than the facility's specific projected cost, and subject to review upon the completion of an audited full year cost report. The negotiated rate shall not be less than the North Carolina statewide Medicaid day-weighted average direct care plus the indirect rate. Rates in subsequent years are determined by applying the index factor as set forth in Section .0102(e) to the negotiated rate in the previous year, unless either the provider or the State requests a renegotiation of the rate within sixty days (60) of the rate notice.

(C) Cost reports for this service shall be filed in accordance with Section .0104 but there shall not be cost settlements for any difference between cost and payments.

(D) A single all-inclusive prospective per diem rate combining both the direct and indirect cost components can be negotiated for nursing facilities that specialize in providing intensive services for ventilator-dependent patients. The negotiated rate is considered to provide payment for all financial considerations and shall not include the return on equity adjustment as defined in Section .0102. The negotiated rate will be paid to the facility for services provided to ventilator patients only. The per diem payment rate for non-ventilator patients shall be the rate calculated in accordance with Section .0102 (b) – (e).

(i) Religious Dietary Considerations.

(1) A standard amount may be added to a nursing facility's rate for special dietary need for religious reasons.

(2) Facilities must apply to receive this special payment consideration. In applying, facilities must document the reasons for special dietary consideration for religious reasons and must submit documentation for the increased dietary costs for religious reasons. Facilities must apply for this special benefit each time rates are determined from a new database. Fifty or more percent of the patients in total licensed beds must require religious dietary consideration in order for the facility to qualify for this special dietary rate add-on.

(3) The special dietary add-on rate may not exceed more than 140% of the base year neutralized case-mix adjusted Medicaid-day-weighted median cost determined under Section .0102(b)(2) and adjusted for inflation each year until a new database is used to determine rates.

.0103 REASONABLE AND NON-ALLOWABLE COSTS

(a) Providers have a responsibility to operate economically and efficiently so that their costs are reasonable. Providers are required to provide services at the lowest possible costs in compliance with Federal and State laws, regulations for licensing and certification, and standards for quality of care and patients' safety. Providers are also responsible for the financial actions of their agents (e.g., management companies) in this regard.

(b) The state may publish guidelines to define reasonable costs in certain areas after study of industry-wide cost conditions.

(c) The following costs are considered non-allowable facility costs because they are not related to patient care or are specifically disallowed under the North Carolina State Plan:

(1) bad debts;
(2) advertising – except personnel want ads, and one line yellow page (indicating facility address);
(3) life insurance (except for employee group plans);
(4) interest paid to a related party;
(5) contributions, including political or church-related, charity and courtesy allowances;
(6) prescription drugs and insulin (available to recipients under State Medicaid Drug Program);
(7) vending machine expenses;
(8) personal grooming other than haircuts, shampooing (basic hair care services) and nail trimming performed by either facility staff or barbers/beauticians. The facility may elect the means of service delivery. The costs of services beyond those provided by the nursing facility are the responsibility of the patient;
(9) state or federal corporate income taxes, plus any penalties and interest;

(10) telephone, television, or radio for personal use of patient;
(11) penalties or interest on income taxes;
(12) dental expenses – except for consultant fees as required by law;
(13) farm equipment and other expenses;
(14) retainers, unless itemized services of equal value have been rendered;
(15) physicians' fees for other than medical directors or medical consultants as required by law;
(16) country club dues;
(17) sitter services or private duty nurses;
(18) fines or penalties;
(19) guest meals;
(20) morgue boxes;
(21) leave days – except therapeutic leave;
(22) personal clothing; and
(23) ancillary costs that are billable to Medicare or other third party payors.

(d) For those non-allowable expenses which generate income, such as prescription drugs, vending machines, hair care (other than basic care), etc., expense should be identified as a non-reimbursable cost center where determinable. If the provider cannot determine the actual amount of expense which is to be identified, then the income which was generated must be offset in full to the appropriate cost center if the income reasonably covers the cost incurred. If income generated does not reasonably cover the cost incurred, an adjustment must be made to recognize a reasonable amount of non-reimbursable cost.

(e) For combination facilities (e.g. Nursing/Adult Care Home), providers must ensure that salary and wage expense coded or allocated to each area considers minimum staffing requirements (nursing hours per patient day or census statistics as appropriate).

.0104 COST REPORTING: AUDITING

(a) Each facility that receives payment from the North Carolina Medicaid Program must prepare and submit an annual report of its costs, including costs to meet the requirements of OBRA 87 (section 1919 of the Social Security Act) and other financial information to include, the facility's original working trial balance, year end adjusting journal entries, and the facility's daily midnight census records for the cost reporting period. The report must include costs from the fiscal period beginning on October 1 and ending on September 30 and must be submitted to the state on or before the December 31 that immediately follow the September 30 year end. A new provider must submit a report for the period beginning with the date of certification and ending on September 30. Hospital based nursing facilities and state operated facilities must file their cost reports within 150 days after their fiscal year ends. Facilities that fail to file their cost reports by the due date are subject to payment suspension as provided for under Section .0107(d)(4) until the reports are filed. The Division of Medical Assistance may extend the deadline 30 days for filing the report if, in its view, good cause exists for the delay. A good cause is an action that is uncontrollable by the provider.

(b) Cost report format. The cost report must be submitted on forms and in a format and medium approved by the Division of Medical Assistance. The account structure for the report is based on the chart of accounts published by the American Healthcare Association in 1979 but amended or modified to the extent necessary to meet the requirements of this plan. The Division of Medical Assistance will make one copy of the cost report format available to each facility (combination facilities receive only one) on or before September 1 of the reporting year for which the report is to be filed.

(c) Cost finding and allocation. Costs must be reported in the cost report in accordance with the following rules and in the order of priority stated.

(1) Costs must be reported in accordance with the specific provisions of this plan as set forth in this Section.

(2) Costs must be reported in conformance with the Medicare Provider Reimbursement Manual, HCFA 15.

(3) Costs must be reported in conformance with Generally Accepted Accounting Principles.

(d) The state will publish guidelines, consistent with the provisions of this plan, concerning the proper accounting treatment for items described in this Section. These guidelines may be modified prior to the beginning of each cost reporting period. In no case, however, shall any modifications be applied retroactively. A provider should request clarification in writing from the state if there is uncertainty about the proper cost center classification of any particular expense item.

(1) Nursing Cost Center includes the cost of nursing staff, medical supplies, and related operating expenses needed to provide nursing care to patients, including medical records (including forms), the Medical Director and the Pharmacy Consultant. The amount of nursing time provided to each patient must be recorded in order to allocate nursing cost between reimbursable and non-reimbursable cost centers.

(2) Dietary Cost center includes the cost of staff, raw food, and supplies needed to prepare and deliver food to patients.

(3) Laundry and Linen Cost Center includes the cost of staff, bed linens (replacement mattresses and related operating expenses needed to launder facility-provided items).